

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-004455

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 54 Registrar's No. 29

FILED JAN 25 1963

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY	St. Louis	a. STATE	MO
b. CITY (If outside corporate limits, give TOWNSHIP only)	Clayton	b. COUNTY	ST. LOUIS
Length of stay in 1b	3 hrs	c. CITY OR TOWN	VALLEY PARK
c. FULL NAME OF HOSPITAL OR INSTITUTION	St. Louis Co. Hosp.	d. STREET ADDRESS	300 BENTON ST
Inside Limits	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Inside Limits	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Reside on Farm	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Reside on Farm	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First	Middle	Month	Day
TEMPEST	FLEMING	JAN	2
Year	1963		
5. SEX	6. COLOR OR RACE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH
FEMALE	WHITE		SEPT 21, 1884
9. AGE (last birthday)	10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY
78	OWN HOME	PULASKI, MO	U.S.A.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	13a. FATHER'S NAME		
HOUSEWORK	JOHN TRAW		
13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE	
SARAH GIDEON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT	
NO		MARY HERBERT	
18. CAUSE OF DEATH (Enter only one cause per item 18. PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days.		INTERVAL BETWEEN ONSET AND DEATH	
Generalized Arteriosclerosis with Marked Cerebral Involvement			
Perisplenic Peritonitis			
20c. TIME OF INJURY		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
Hour	Month, Day, Year		
a.m.			
p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY	
20g. STATE			
21. I attended the deceased from 1-2-63 to 1-2-63 and last saw her alive on 1-2-1963			
Death occurred at		on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE		22b. ADDRESS	
H.R. Gilbert, M.D.		601 S. Brentwood	
22c. DATE SIGNED		1-3-63	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	
BURIAL	JAN 5, 1963	23c. NAME OF CEMETERY OR CREMATORY	
		SACRED HEART	
24. FUNERAL DIRECTOR		25. DATE RECD. BY LOCAL REG.	
SCHVADER FUNERAL HOME		1-4-63	
ADDRESS		26. REGISTRAR'S SIGNATURE	
BALDWIN, MO.		John. Murphy, M.D.	

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Richard Bopp

Licensed Embalmer No.

4584

P. O. Address

Ballerwin, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.